PRIOR AUTHORIZATION FOR PRIVATE DUTY NURSING (PDN)

CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)

Instructions for MSA-0732

The Medicaid Program has developed the Prior Authorization for Private Duty Nursing (PDN) form (MSA-0732). This form is to be used for persons with CSHCS or Medicaid coverage, except those beneficiaries enrolled in, or receiving case management services from, the Children's Waiver, Habilitation Supports Waiver, or MI Choice Waiver.

The MSA-0732 may be completed by community-based medical personnel (e.g., hospital discharge planner, private duty nursing provider, etc.).

Providers are not to submit form CMS 485 with the authorization form.

If services are approved, the provider will receive an authorization letter. For continued authorization, the provider must submit the MSA-0732 and required documentation within 15 days prior to the end date of the current authorization. The required documentation includes medical reports that support the need for private duty nursing as identified on the authorization form; a proposed 24-hour nursing plan of care at the end of the initial 30 days and for each 90-day interval. For each re-authorization, two recent seven-day periods of nursing notes must be submitted that demonstrate the beneficiary's current clinical need for private duty nursing.

Physician and Parent/Guardian signatures on the MSA-0732 are required on an annual basis and when the plan of care is updated as needed based on the beneficiary's needs.

If there are no changes to items on pages 2 and 3, note "No Changes" in the applicable item. The MSA-0732 must be completed in its entirety annually and when changes occur.

Note: The purpose of the PDN benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. The benefit is not intended to supplant the care giving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary care giver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18 and the care giver must provide a monthly average of a minimum of eight hours of care during a typical 24-hour period.

Providers may download the form off the MDCH website at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Medicaid Provider Forms and Other Resources. The MSA-0732 can also be ordered from the Michigan Department of Community Health, Forms Distribution, 320 S. Walnut St., Lansing, MI 48913.

The completed MSA-0732 may be mailed or faxed to:

Michigan Department of Community Health
Children's Special Health Care Services
3423 N. MLK Blvd.
PO Box 30734
Lansing, MI 48909

Fax: (517) 335-8454

Questions should be directed to (517) 335-8983.

PRIOR AUTHORIZATION FOR PRIVATE DUTY NURSING (PDN)
CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)

BENEFICIARY INFORMATION:

1. LAST NAME	2. FIRST NAME			3. M.I.	4. MEDICAID I.D. #
5. STREET ADDRESS (APT., ETC.)				6. SEX	7. DATE OF BIRTH
8. CITY	9. STATE MI	10. ZIP -	11. COUNTY		12. PHONE NUMBER ( ) -

MEDICAL CARE/TREATMENT AND CLINICAL INFORMATION RELEVANT FOR MEDICAID COVERED PDN:

13. Medical documentation must be attached or documented below (14.) to support the intensity of care required, as well as to provide additional clinical information to support the need for coverage of PDN. The referring physician or appropriate subspecialist must complete the following information:

Name of Physician Ordering PDN: _____

Address of Physician: _____

I certify that this information, with attachments, clearly identifies the current treatment and service needs of the beneficiary. The plan submitted indicates that PDN is medically necessary, as defined in Medicaid policy. I will manage the PDN for the beneficiary, including annual review of the home care plan, or delegate the responsibility to:

Name of Physician: _____

14. IF NOT ATTACHING DOCUMENTS, EXPLAIN BELOW WHY THE BENEFICIARY REQUIRES CARE BY A LICENSED NURSE:

15. Physician Signature:	16. Phone: ( ) -	17. DATE:

Note: Physician signature required annually and when the plan of care is updated based on the beneficiary's needs.

18. WHAT ARE THE SKILLED NURSING CARE NEEDS OF THE BENEFICIARY? LIST ALL ASSESSMENTS, JUDGMENTS AND INTERVENTIONS REQUIRED, WITH A STATEMENT OF EXPECTED FREQUENCY OF NEED. ATTACH PROPOSED 24-HOUR NURSING PLAN OF CARE TO BE RENDERED IN THE HOME AND TWO RECENT SEVEN-DAY PERIODS OF NURSING NOTES.

BENEFICIARY'S LAST NAME	FIRST NAME	MEDICAID ID #

HOME ENVIRONMENT:

19. NUMBER OF SIBLINGS: _____

20. NUMBER OF OTHER INDIVIDUALS IN THE HOME: _____

21. NUMBER OF CARE GIVERS: _____

22. NUMBER OF CARE GIVERS WHO WORK OR ATTEND SCHOOL OUTSIDE OF THE HOME: _____

23. CARE GIVER'S NAME: _____ NO. OF HRS/DAYS WORKING: _____

CARE GIVER'S NAME: _____ NO. OF HRS/DAYS WORKING: _____

24. CAN PDN BE SAFELY PROVIDED IN A HOME SETTING? YES ☐ NO ☐

25. PERSON/AGENCY MANAGING THE PDN PLAN: _____

SCHOOL:

26. IS BENEFICIARY CURRENTLY IN SCHOOL? YES ☐ NO ☐ IF YES, HOW MANY HOURS? _____ PER DAY _____ PER WEEK (INCLUDING TRAVEL TIME)

HOSPITALIZATION:

27. IS BENEFICIARY CURRENTLY HOSPITALIZED? YES ☐ NO ☐

IF YES, ANTICIPATED DISCHARGE DATE: __/__/____

NAME OF HOSPITAL: _____

NAME OF DISCHARGE COORDINATOR: _____

28. HOSPITAL TO BE USED IN THE FUTURE: _____

29. PHYSICIAN'S NAME COORDINATING BENEFICIARY'S DISCHARGE: _____

PHYSICIAN'S TELEPHONE:	
PHYSICIAN'S ☐ PAGER OR ☐ CELL OR ☐ FAX:	
PHYSICIAN'S E-MAIL ADDRESS:	

30. PHYSICIAN'S NAME COORDINATING CARE IN THE COMMUNITY: _____

PHYSICIAN'S TELEPHONE:	
PHYSICIAN'S ☐ PAGER OR ☐ CELL OR ☐ FAX:	
PHYSICIAN'S E-MAIL ADDRESS:	

HEALTH INSURANCE/OTHER PUBLICLY FUNDED PROGRAMS:

31. NAME OF PRIVATE HEALTH INSURANCE: _____

PRIVATE HEALTH INSURANCE POLICY NUMBER: _____

32. NAME OF OTHER PUBLICLY FUNDED PROGRAMS THAT THE BENEFICIARY IS BEING SERVED UNDER: _____

PARENT/GUARDIAN REQUEST AND AGREEMENT:

33. NUMBER OF PDN HOURS PER DAY REQUESTED BY FAMILY: _____

34. I AM APPLYING FOR PRIVATE DUTY NURSING FOR _____.

I agree to the release of information from this PDN application and supporting proof in order to evaluate and verify PDN eligibility. I agree that the Department of Community Health (DCH) or Family Independence Agency (FIA) may use or disclose necessary medical information about me or my children, including any mental health, substance abuse, HIV, ARC, or AIDS information, to determine eligibility for a specific program or for treatment, payment, health care operations, or other administrative purposes. I understand that these agencies will maintain confidentiality according to the Health Insurance Portability and Accountability Act, 45 CFR 164.102 – 164.534, and any other applicable federal and state laws and regulations. This consent is valid for 3 years from the date this application is signed. I understand that I am obligated to participate in the daily provisions of care and that my child must maintain Medicaid eligibility for this benefit.

Parent/Guardian Signature: _____ Date: _____

Note: Parent/Guardian signature is required annually and when substantive changes are made to the plan of care.

BENEFICIARY'S LAST NAME	FIRST NAME	MEDICAID ID #

PROVIDER INFORMATION: (NAME OF MEDICAID ENROLLED PRIVATE DUTY NURSING AGENCY, R.N., OR SUPERVISING R.N. FOR THE MEDICAID ENROLLED LPN WHO WILL PROVIDE SERVICE.)

35. PROVIDER #1: START OF SERVICE DATE: __/__/____

Provider Name: _____

Street Address: _____

_____

City: _____ State: __ Zip _____ - ____

Medicaid Provider ID Number: _____ _____ Provider Phone Number: (___) ____-____

PDN Provider Signature: _____

36. PROVIDER #2: START OF SERVICE DATE: __/__/____

Provider Name: _____

Street Address: _____

_____

City: _____ State: __ Zip _____ - ____

Medicaid Provider ID Number: _____ _____ Provider Phone Number: (___) ____-____

PDN Provider Signature: _____

37. Medical Supplier/DME Name: _____

Provider Phone Number: (___) ____-____

MDCH CONSULTANT USE ONLY

☐ APPROVED ☐ AMENDED ☐ DENIED ☐ PENDED

Comment: _____

For Number of Hours Per Day: _____ From: __/__/____ To: __/__/____

MDCH AUTHORIZED SIGNATURE:

_____ DATE: _____

_____ DATE: _____